MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00782

787

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes (4 days)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 306 Cannon Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA — Middle MAY — Last BRATCHER

4. DATE OF DEATH: Month January — Day 4 — Year 19XX 58

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 10, 1902

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charlie Turner

14. MOTHER'S MAIDEN NAME: Gertride ~~Brown~~ Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-12-4738

17. INFORMANT — Address: Hospital Records Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

331x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arterial Hypertension — several years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1, 1958 to January 4, 1957, that I last saw the deceased alive on January 5, 1958, and that death occurred at 11:55P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D.

ADDRESS (Street, city or town, state): Chestertown, Maryland

DATE SIGNED: 1/5/58

PHYSICIAN'S NAME (Type): ~~KKKKKKK~~ ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: I/8/58

22c. NAME OF CEMETERY OR CREMATORY: Janes Cemetery

22d. LOCATION (City, town, or county) (State): near - Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker

ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 8 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00783

797 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY KENT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SASSAFRAS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SASSAFRAS
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First PERRY Middle HENRY Last BROWN

4. DATE OF DEATH Month JAN. Day 25 Year 1958

5. SEX M. 6. COLOR OR RACE COL. 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH APRIL 22, 1891 9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION BUILDING
10b. KIND OF BUSINESS OR INDUSTRY BUILDING
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME PERRY BROWN
14. MOTHER'S MAIDEN NAME MARY WARNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-12-3757
17. INFORMANT GEORGANNA BROWN Address SASSAFRAS, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency & decomp. — 1-2 weeks
DUE TO (c)

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 24, 19 58, to Jan 25, 19 58, that I last saw the deceased alive on Jan 24, 19 58, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H.H. Hamilton M.D. ADDRESS (Street, city or town, state) Millington DATE SIGNED 1/27/58

PHYSICIAN'S NAME (Type) H.H. HAMILTON

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1/30/58
22c. NAME OF CEMETERY OR CREMATORY Wesley Henry Cem.
22d. LOCATION (City, town, or county) (State) Golt, MD.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington, Md.
24a. REC'D BY REGISTRAR DATE JAN 31 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00784

788 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 4 houfs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent and Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Golt
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: Last: Byard
4. DATE OF DEATH: Month: January Day: 29 Year: 19 58

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 30, 1930
9. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Byard
14. MOTHER'S MAIDEN NAME: Mattie Goldsberry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Concussion and shock — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
983x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Deceased was attacked about 11:00 P.M. near his home in Golts, Md. Brought to the Kent and Queen Anne Hosp.
DUE TO (c): in Chestertown 2:30 A.M. He was found to be suffering from multiple lacerations of the head due to blows
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): with a club. He was severely shocked from exposure to cold and his injuries. Death occurred 6:30 A.M.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: 11:00 a.m. p.m. Month, Day, Year: 1/28 19 58
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Golts, Md.
20f. (City or town): Golts (County): Kent (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W Farr M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED
EXAMINER'S NAME (Type): Robert W. Farr, M. D. 1/29/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/3/58
22c. NAME OF CEMETERY OR CREMATORY: Lake Cm.
22d. LOCATION (City, town, or county): Middletown (State): Del.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellow ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: FEB 7 58
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

798 CERTIFICATE OF DEATH

Reg. Dist. No. 10785

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Charles Middle S. Last Church

4. DATE OF DEATH Month Jan. Day 30 Year 1958

5. SEX M.

6. COLOR OR RACE W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct. 21, 1886

9. AGE (In years last birthday) 71 yrs.

IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-District Man

10b. KIND OF BUSINESS OR INDUSTRY E.S.P. Service Co.

11. BIRTHPLACE (State or foreign country) Bergan, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George H. Church

14. MOTHER'S MAIDEN NAME Belle Farnham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-03-8658

17. INFORMANT Address Mrs. Helen B. Church, Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 3 years

177X

DUE TO (b) Prostatic Malignancy — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1953, to Jan 30, 1958, that I last saw the deceased alive on Jan 30, 1958, and that death occurred at 6.10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H.H. Hamilton M.D. ADDRESS (Street, city or town, state) Millington Md DATE SIGNED 1/31/58

PHYSICIAN'S NAME (Type) H.H. HAMILTON

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 2/1/58

22c. NAME OF CEMETERY OR CREMATORY Millington Cem.

22d. LOCATION (City, town, or county) (State) Millington Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington Md

24c. REC'D BY REGISTRAR DATE FEB 6 58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00786

Reg. Dist. No. 733

1. PLACE OF DEATH
a. COUNTY: Kent. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena – (Georgetown)
c. LENGTH OF STAY IN 1b: Entire life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena (George town)
d. STREET ADDRESS: X 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLARD Middle BURTON Last EDWARDS
4. DATE OF DEATH: Month January Day 5 Year 1958
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 31, 1894
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bridge tender
10b. KIND OF BUSINESS OR INDUSTRY: State Roads Comm.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Joseph Edwards
14. MOTHER'S MAIDEN NAME: Carrie King
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-22-3931
17. INFORMANT: (Name) Mrs. Stacy Edwards Address: galena md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Unknown, but probably cardiac. — INTERVAL BETWEEN ONSET AND DEATH: Short
795.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Unable to work 6 days prior to 1/5/58. Last seen alive 30 days prior to 1-5-58
DUE TO (c): Found dead 6 a.m. 1-5-58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Robert W. Farr M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): ROBERT W. FARR
DATE SIGNED: 1/5/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 8 1958
22c. NAME OF CEMETERY OR CREMATORY: Massey Cemetery
22d. LOCATION (City, town, or county) (State): Massey Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Elwood Tolliver ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR DATE: JAN 13 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

789 **CERTIFICATE OF DEATH**

00788
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 34 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Ann's

2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d STREET ADDRESS: /
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle B Last Elbourn

4 DATE OF DEATH: Month January Day 4 Year 19 58

5. SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 27, 1902
9 AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Fishing, dockbuilding
11. BIRTHPLACE (State or foreign country): Rock Hall, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas J. Elbourn
14. MOTHER'S MAIDEN NAME: Sara Kendall

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured aneurysm of abdominal aorta — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2, 1958, to 1-4, 1958, that I last saw the deceased alive on 1-4, 1958, and that death occurred at 12:55a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. ADDRESS (Street, city or town, state): Chestertown, Maryland DATE SIGNED: 1-4-58

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/6/58
22c. NAME OF CEMETERY OR CREMATORY: St. Paul's
22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: JAN 5 58
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

790 CERTIFICATE OF DEATH

Reg. Dist. No. 00787

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 110 Spring Ave.

d. STREET ADDRESS: 110 Spring Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marguerite Middle Cree Last Elison

4. DATE OF DEATH: Month Jan. Day 5 Year 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 6 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Ft.McHenry, Balto, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John K. Cree

14. MOTHER'S MAIDEN NAME: Agnes Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Thos. W. Elison, Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable acute coronary insufficiency with pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: a few minutes
DUE TO (b): Coronary sclerosis & aortic stenosis at least 6 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/19, 1957, to 1/5, 1958, that I last saw the deceased alive on 1/5, 1958, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Chestertown, Md. DATE SIGNED: 1/6/58

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.7/58

22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 9 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

800

Reg. Dist. No. 00789

1. PLACE OF DEATH
a. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRLEE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairlee (rural chestertown)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JAMES Last FRENCH

4. DATE OF DEATH: Month JAN Day 2 Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 6, 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Alfred French

14. MOTHER'S MAIDEN NAME: Anna [illegible] Venables

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-36-5446

17. INFORMANT: Address: Mrs Mary Hatcheson, Chestertown, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Natural causes, Int unknown Dur,
DUE TO (b): Probably congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Dont know
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was found dead in bed. Was last seen alive 11 PM 1-1-58, Last seen alive 11 PM

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Robert Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1/2/58

EXAMINER'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Jan. 4, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem.

22d. LOCATION (City, town, or county) (State): nr. - Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.

24c. RECEIVED BY REGISTRAR DATE: JAN 3 1958

24b. REGISTRAR'S SIGNATURE: A. J. McAuley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(5)
5M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791 CERTIFICATE OF DEATH

Reg. Dist. No. 00790

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown (Rural)
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Agnes; Middle; Last Goldsborough
4. DATE OF DEATH: Month Jan; Day ~~X~~28; Year 1958
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ~~April~~ March 26, 1904
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Wright
14. MOTHER'S MAIDEN NAME: Mary Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-32-7879
17. INFORMANT: Address: Hospital records Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intrad ranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8-9 hours
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b) Arterial Hypertension — Several years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/15, 1958 to 1/28/, 1958, that I last saw the deceased alive on 1/28/58, 19____, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 1/29/58

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. I, 1958
22c. NAME OF CEMETERY OR CREMATORY: Broad Neck Cem. near
22d. LOCATION (City, town, or county) (State): Chestertown. ~~xdm~~ Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walby
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JAN 3 0 58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00791

File No. 801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Still Pond
c. LENGTH OF STAY IN 1b: 70 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: ---

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Still Pond
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willis — Middle: K. — Last: Hackett

4. DATE OF DEATH: Month: January — Day: 25, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1867

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cannery

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew J. Hackett

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Cavender

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. E. K. Jones — Address: Still Pond, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: ___ o. m. p. m. — Month: ___ Day: ___ Year: 19___

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-23, 19 58, to 1-25, 19 58, that I last saw the deceased alive on 1-23-58, 19 58, and that death occurred at 3:00a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. C. Dick M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 1-25-58

PHYSICIAN'S NAME (Type): A. C. Dick M. D. — Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/27/58

22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cemetery

22d LOCATION (City, town, or county) (State): Still Pond, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: JAN 28 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M II/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00792

792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S.

2 USUAL RESIDENCE (Where deceased lived. If institution · Residence before admission)
a. STATE: Md — b. COUNTY: KENT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 CHESTERTOWN
d. STREET ADDRESS: 1202 LYNCHBURG
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELIA — Middle — Last HOLLEY
4. DATE OF DEATH: Month JAN. — Day 7 — Year 1958

5. SEX: F
6. COLOR OR RACE: COL.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Mar. 3, 1910
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): KENT, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS HOLLEY
14. MOTHER'S MAIDEN NAME: JOSEPHINE MITCHELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: HOSPITAL CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 446X UREMIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) RENAL ARTERIOSCLEROSIS.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETIC GANGRENE, LEG

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 7, 1958, to JAN 7, 1958, that I last saw the deceased alive on JAN 7, 1958, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. T. Keefe Jr. M.D.
ADDRESS (Street, city or town, state): CHESTERTOWN Md
DATE SIGNED: 1-7-58
PHYSICIAN'S NAME (Type): A. T KEEFE, JR. M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/9/58
22c. NAME OF CEMETERY OR CREMATORY: James Cemetery
22d. LOCATION (City, town, or county) (State): Near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walby
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JAN 13 '58
24b. REGISTRAR'S SIGNATURE: Athern

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Note Corrections Made at Kent and Queen Annes Hospital Record Room.

R. M. Bowes. M. R. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

802

Reg. Dist. No. 00793

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
c. LENGTH OF STAY IN 1b: 55 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kennedyville
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: James Last: Hopkins

4. DATE OF DEATH: Month: January Day: 10, Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 31, 1877

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: 213-22-8575

17. INFORMANT: Norman Hopkins Address: Kennedyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension — years
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/11, 1957, to 1/10, 1958, that I last saw the deceased alive on 1/10, 1958, and that death occurred at 6:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Solon M.D. ADDRESS (Street, city or town, state): Chestertown, MD. DATE SIGNED: 1/10/58

PHYSICIAN'S NAME (Type): Thomas Solon Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/12/58
22c. NAME OF CEMETERY OR CREMATORY: Crumpton Cemty
22d. LOCATION (City, town, or county) (State): Crumpton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: JAN 13 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

793 **CERTIFICATE OF DEATH** Reg. Dist. No. 00794

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Ann

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lynch
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lelia Middle: H. Last: Hossinger

4. DATE OF DEATH: Month: January Day: 29 Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1866

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis S. Hepburn

14. MOTHER'S MAIDEN NAME: Mary E. Roseberry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Old age
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 15, 1958, to Jan. 29, 1958, that I last saw the deceased alive on Jan. 28, 1958, and that death occurred at 10:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 1-29-58

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-1-58
22c. NAME OF CEMETERY OR CREMATORY: STILL POND CEMTY
22d. LOCATION (City, town, or county) (State): STILL POND MD

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: STILL POND, MD.

24a. REC'D BY REGISTRAR DATE: JAN 31 '58
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1 893

Reg. Dist. No. 00795

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETTERTON
c. LENGTH OF STAY IN 1b: 4 1/2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BETTERTON
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: FLORENCE — Middle: Scoville — Last: Lloyd

4. DATE OF DEATH: Month: JAN — Day: 17 — Year: 1958

5 SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: JAN 16, 1887

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): CHICAGO, ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: AMASA U. Scoville

14. MOTHER'S MAIDEN NAME: MAY Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: —

17. INFORMANT: SHERMAN C LLOYD SR. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b): CEREBRAL VASCULAR ACCIDENTS — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): ARTERIO SCLEROSIS — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1957 to Jan 17, 1958, that I last saw the deceased alive on Jan 17, 1958, and that death occurred at 8 3/4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D. — ADDRESS (Street, city or town, state): Worton, Md — DATE SIGNED: Jan 17, 1958

PHYSICIAN'S NAME (Type): FLORENCE DERINGER JOYCE — WORTON, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 1-20-58

22c NAME OF CEMETERY OR CREMATORY: WILMINGTON + BRANDYWINE

22d LOCATION (City, town, or county) (State): WILMINGTON DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: STILL POND, MD.

24a. REC'D BY REGISTRAR DATE: JAN 20 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Kent [illegible] Maryland Kent

Betterton [illegible] Betterton

Florence Scoville Lloyd Jan 17 58

F W Jan 16 1887 70

Housewife Home Chicago, Illinois U S

[illegible] C. Scoville [illegible] Illinois

no — Sherman C Lloyd Sr.

Uremia [illegible]

Cerebral vascular accidents 5 yrs

Arterio sclerosis

Jan 17 58 [illegible] Jan 17 58

Florence Beringer Joyce Norton MD

Burial 1-20-58 Wilmington + Brandywine Wilmington Del

[illegible] Still Pond, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

CERTIFICATE OF DEATH

794

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown

c. LENGTH OF STAY IN 1b Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural

d. STREET ADDRESS Rural

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF [redacted] (Type or print) First Abbie Middle Estella Last Quinn

4. DATE OF DEATH Month Jan. Day 19, Year I958

5. SEX female

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Mar. 2, I876

9. AGE (In years last birthday) 81 yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Queen Anne Co. Maryland

12. CITIZEN OF WHAT COUNTRY? Maryland

13. FATHER'S NAME Joseph Loller

14. MOTHER'S MAIDEN NAME Kathryn Pardee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. no

17. INFORMANT Address Mrs. Mary Bonwill Still Pond, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive - Cardio Vascular

DUE TO (c) Arterio Sclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1 1957 to Jan 19 1958 that I last saw the deceased alive on Jan 19 1958, and that death occurred at 1:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Norbert C Nitsch M.D. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED

PHYSICIAN'S NAME (Type) NORBERT C NITSCH Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Jan. 2I, I958

22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery

22d. LOCATION (City, town, or county) Chestertown, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.

24a. REC'D BY REGISTRAR DATE JAN 2 1 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

804 CERTIFICATE OF DEATH

Reg. Dist. No. 00797

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LINDA Middle M. Last SMITH

4. DATE OF DEATH: Month Jan. Day 26 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 27 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Phila. Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel L Hoover
14. MOTHER'S MAIDEN NAME: Julia McCurdy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Mrs Mae Mulford Galena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Massive metastases	6 mos.
DUE TO (b)	Breast Carcinoma. (rt Breast).	3 years.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Massive pleural effusion secondary to above.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 15, 19 57, to Jan 26, 19 58 that I last saw the deceased alive on Jan 26, 19 58, and that death occurred at 12 50 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. ADDRESS (Street, city or town, state): Cecilton, Md DATE SIGNED: 27 Jan 58.

PHYSICIAN'S NAME (Type): WALLACE OBENSHAIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 28 1958
22c. NAME OF CEMETERY OR CREMATORY: Cecilton Cem
22d. LOCATION (City, town, or county) (State): Cecilton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellar ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: JAN 31 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1 805 — 00798 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — BALTIMORE

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ———

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: [illegible]yland — b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

d. STREET ADDRESS: 16 Hawthorne Ave;

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Lillian — Last: Smith

4. DATE OF DEATH: Month: Jan. — Day: 11 — Year: 19[illegible]

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. [illegible]

9. AGE (In years last birthday): [illegible] yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Smith--Rock Hall, Mary[illegible] — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cardio Vascular — Unknown

DUE TO (c): Coronic Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1 1957, to Jan 11 1958, that I last saw the deceased alive on Jan 11 1958, and that death occurred at 11:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Nitsch, M.D. — ADDRESS (Street, city or town, state): Rock Hall — DATE SIGNED

PHYSICIAN'S NAME (Type): NORBERT C. NITSCH — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF:

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: JAN 20 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

806 **CERTIFICATE OF DEATH**

Reg. Dist. No. 00799

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ear Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: ar land — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kennedyville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Flora — Middle: Belle — Last: Jour in
4. DATE OF DEATH: Month: Jan. — Day: [illegible] — Year: 19

5. SEX: [illegible]
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Feb. 12 18[illegible]7
9. AGE (In years last birthday): [illegible] yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]ewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Bolli[illegible] ; Green Isl.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sanford Reynolds
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: [illegible]10
17. INFORMANT — Address: Mrs. J. O. Black Kennedtville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HT. DISEASE — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): SENILITY
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/7 1956, to 1/26 1958, that I last saw the deceased alive on 1/17 1958, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph A. Elliott M.D. — ADDRESS (Street, city or town, state): 714 West St. Laurel Del. — DATE SIGNED: 1/26/58
PHYSICIAN'S NAME (Type): JOSEPH A. ELLIOTT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/28/57
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
22d. LOCATION (City, town, or county) (State): near Fairlee, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: JAN 29 '58
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

807 CERTIFICATE OF DEATH

Reg. Dist. No. 00800

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: ---
d STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Betterton

3. NAME OF DECEASED (Type or print): First John — Middle C. — Last Sutton
4. DATE OF DEATH: Month January — Day 4, — Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 18, 1864
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Carvel Sutton
14. MOTHER'S MAIDEN NAME: Caroline Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): ---
16 SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Arthur G. Sutton, Chester, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis — years
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o m. p. m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1958, to Jan 4, 1958, that I last saw the deceased alive on Jan 4, 1958, and that death occurred at 6:3/p M, from the causes and on the date stated above

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton — DATE SIGNED: 4 Jan 58
PHYSICIAN'S NAME (Type): WALLACE OBENSHAIN — Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/6/58
22c. NAME OF CEMETERY OR CREMATORY: Shrewsbury Cemetery
22d LOCATION (City, town or county) (State): Kennedyville, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: Still Pond, Md.
24a. REC'D BY REGISTRAR DATE: JAN 8 '58
24b. REGISTRAR'S SIGNATURE: C. W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

Dictated but not read

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

808

Reg. Dist. No. 00801

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: several years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XRock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Nelson; Last: Urie

4. DATE OF DEATH: Month: Jan.; Day: 29; Year: 19 58

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: May 9, ~~1900~~ 1899

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired fireman

10b. KIND OF BUSINESS OR INDUSTRY: Balto. Fire Dept.

11. BIRTHPLACE (State or foreign country): ~~XXXX~~ Rock Hall, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Urie

14. MOTHER'S MAIDEN NAME: Anna Downey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Lawrence Urie, Rock Hall, Md. (brother)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Unknown but probable heart attack — INTERVAL BETWEEN ONSET AND DEATH: very short

DUE TO (b): Went to his room for the night 1/28/58 at 10:00P.M.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Found dead in the floor at the foot of his bed 8:00A.M 1/29/58. Has always been in good health and was apparently well when he retired. Has had no pain in chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): shortness of breath or indigestion. Rigormortis was complete when he was found.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ENTER IF CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Robert W Farr M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1/29/58

NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 1

22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

22d. LOCATION (City, town, or county) (State): Rock Hall, md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill, Md

24a. REC'D BY REGISTRAR DATE: FEB 4 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00802

795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY KENT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHurch Hill
d. STREET ADDRESS 17 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ESTELLE Middle Last WALLS

4. DATE OF DEATH: Month January Day 1 Year 1958

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 4, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel C Walls
14. MOTHER'S MAIDEN NAME: Mary Rigby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Hospital records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracranial hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterial Hypertension, & Hypertensive cardio-vascular Disease — Many years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 28, 1957 to Jan 1, 1958, that I last saw the deceased alive on January 1, 1958, and that death occurred at 10:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Maryland
DATE SIGNED: Jan 1, 1958

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: JAN 3
22c. NAME OF CEMETERY OR CREMATORY: Church Hill
22d. LOCATION (City, town, or county) (State): Church Hill Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill Md.
24a. REC'D BY REGISTRAR DATE: JAN 6 1958
24b. REGISTRAR'S SIGNATURE: A. Hudnut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

796 **CERTIFICATE OF DEATH** 00803

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: 5 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Zungaila

4. DATE OF DEATH: Month: January — Day: 10 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 15,1893

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpanter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): XXXXXXX Lithuania

12. CITIZEN OF WHAT COUNTRY?: Don't know

13. FATHER'S NAME: John Zungaila

14. MOTHER'S MAIDEN NAME: Catherine Martinkis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Don't know

16. SOCIAL SECURITY NO.: Don't know

17. INFORMANT — Address: Hospital Records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ~~Coronary~~ Congestive Heart Failure & Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

433.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Auricular Fibrillation & Probable Exposure — Unknown

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan/5, 1958, to Jan. 10, 1958, that I last saw the deceased alive on January 10, 1958, and that death occurred at 6:00A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Warr M.D. — ADDRESS (Street, city or town, state): Chestertown Md. — DATE SIGNED: 1/10/58

PHYSICIAN'S NAME (Type): Robert W. Farr, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.13, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Johns Cem.

22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 13 '58

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55